



**City of New York
Office of Labor Relations
Health Benefits Program**

Notice of Rights

WHEN YOUR HEALTH BENEFITS TERMINATE

The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-2721, Title X), also known as COBRA, was enacted April 7, 1986. This law requires that, effective July 1, 1987, in addition to offering normal conversion opportunities, the City and the union welfare funds must offer employees and their families the opportunity for a temporary extension of group health and welfare fund coverage (called "continuation of coverage") at 102% of the group rates, in certain situations in which benefits under either City basic or the applicable welfare fund would be reduced or terminated. This notice is intended to inform you of your rights and obligations under the continuation coverage provisions of this law as well as your normal conversion option.

As a result of collective bargaining agreements, Medicare-eligible enrollees and/or their Medicare-eligible dependents will be offered continuation benefits similar to COBRA if a COBRA event should occur. **(See Medicare-Eligible Section.)**

Employees

All City group health benefits including the optional benefits riders are available under COBRA continuation coverage. Welfare fund benefits eligible for continuation under COBRA are dental, vision, prescription drugs and other related medical benefits. Welfare funds offer core benefits (prescription drugs and major medical plans) and non-core benefits (dental and vision) which may be purchased separately or combined with City core benefits.

If you are a non-Medicare-eligible employee covered by the City program, you have the right, in certain situations, to continue benefits if you lose your coverage because of a reduction in your hours of employment; or upon the termination of your employment (for reasons other than gross misconduct on your part); or if you take an unpaid leave of absence. If you are Medicare-eligible, you may be entitled to continuation of coverage as is described in the Medicare-eligible section below.

Retirees

If you retire from the City, receive a pension check from a City approved retirement system, you have five years of credited service, if your date of hire was prior to December 27, 2001 or 10 years of credited service if your date of hire was on or after December 27, 2001 and have worked regularly at least 20 hours per week, you and your dependents are eligible to receive City-paid health care coverage.

If you do not meet these eligibility requirements, you and your dependents (if not Medicare-eligible) may continue under COBRA the benefits you received as an active employee, for a period of 18 months at 102% of the City's cost. If your welfare fund benefits are reduced at retirement, you are eligible to continue those benefits that were reduced under the welfare fund as a COBRA enrollee for a period of 18 months at 102% of the cost to the union welfare fund. You should contact your union welfare fund for the premium amounts and benefits available. A list of welfare fund administrators is enclosed or can be obtained from your payroll or personnel office. If you are eligible for Medicare, see the Medicare-eligible section.

Spouse/Domestic Partners and Dependents

If you are the non-Medicare-eligible spouse/domestic partner of an eligible employee or a retiree, you have the right to continue coverage under any of the available NYC health benefits plans and the applicable welfare funds if your health insurance or welfare fund benefits are reduced or terminated for any of the following reasons:

- 1) The death of your spouse/domestic partner;
- 2) The termination of your spouse/domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse/domestic partner's hours of employment;
- 3) Divorce or legal separation from your spouse.

In the case of an eligible dependent child of an employee or retiree (including a newborn child who was born to the covered beneficiary or an adopted child who is placed for adoption with the covered beneficiary during a period of COBRA continuation coverage) he or she has the right to continue coverage under any of the available NYC health benefits plans and the applicable welfare fund if coverage is reduced or terminated for any of the following reasons:

- 1) The death of the covered parent;
- 2) The termination of the covered parent's employment (for reasons other than gross misconduct) or reduction in the parent's hours of employment;
- 3) The dependent ceases to be a "dependent child" under the terms of the Employee Benefits Program;
- 4) Retirement of the covered parent (see "Retiree" above).

If you are a Medicare-eligible spouse/domestic partner or dependent, see section on Medicare-eligible's.

Disabled Persons

If a disability has led to Medicare eligibility, see section on Medicare-eligibles below.

Covered persons who are disabled, under the definition established by the Social Security law, up to 60 days after the COBRA qualifying event of termination of employment or reduction of hours, are entitled to continue coverage for up to a total of twenty-nine (29) months from the date of the initial qualifying event. The cost of coverage during the last eleven (11) months of this extended period is one hundred and fifty percent (150%) of the City cost for the benefit. Persons so disabled must inform the health plan within sixty (60) days of the disability determination and within thirty (30) days of disability ceasing.

Medicare-Eligibles

Employees, retirees, spouses/domestic partners and dependents who are eligible for Medicare may be eligible to receive continued coverage, similar to COBRA, under the City's Medicare-Supplemental plans. Periods of eligibility shall date from the original qualifying event up to eighteen (18) months in the case of loss of coverage because of termination of employment or reduction in hours, or up to thirty-six (36) months in the case of loss of coverage for all other reasons.

If a COBRA qualifying event occurs and you lose coverage, but you and/or your dependents are Medicare-eligible, you may continue coverage by using the COBRA Continuation of Coverage application form. You should indicate your Medicare claim number and effective dates where indicated on the form for Medicare-eligible family members. If you and/or your dependents are about to become eligible for Medicare, and are already continuing coverage under COBRA, inform the carrier of Medicare eligibility for you and/or your dependents, at least thirty (30) days prior to date of Medicare eligibility. COBRA-enrolled dependents of the person who becomes Medicare eligible will be able to continue their COBRA coverage, whether or not the Medicare-eligible person enrolls in the Medicare-Supplemental coverage. The COBRA continuation period for dependents will be unaffected by the decision of the Medicare-eligible employee or retiree.

NOTE: You should contact your carrier for information about other Medicare-Supplemental plans which are offered; some other plans may be better suited to your needs and/or less costly than the plan which is provided under the City's contract.

Notice

Under the law you have sixty (60) days from the date you receive this notice to elect continuation coverage for your City basic and/or optional benefits. Contact your welfare fund administrator for further instructions on how to continue your welfare fund benefits. Payments of the initial monthly premium may accompany the enclosed Continuation of Coverage Application opting for continuation. However, under the law you have a grace period of 45 days from the date you applied for COBRA coverage to pay the premium. You will receive a partial bill for any remaining portion of the following calendar month to bring your billing date to the first of the month. All subsequent bills will be charged from the first day of the month during your COBRA continuation period. Payment shall be on a monthly basis. There is a 30-day grace period for subsequent late payments.

If you choose COBRA continuation coverage, and you are not Medicare-eligible, the City is required to offer you the same coverage which is provided to similarly situated employees, retirees or family members. The law requires that you be afforded the opportunity to maintain continuation coverage for a maximum of thirty-six (36) months unless you lost coverage because of a termination of employment or reduction in hours. In the latter case, the required continuation coverage period is a maximum of 18 months. The maximum period of continuation begins on the first day of the month following the month in which the initial qualifying event occurred, regardless of when any additional events may take place. However, the law also provides that your continuation of coverage may be cut short for any of the following reasons:

- 1) The premium for continuation coverage is not paid in a timely fashion;
- 2) The continuation enrollee becomes covered as an employee or dependent under another group health or welfare plan (under this occurrence the spouse and dependents may continue their COBRA coverage for the remaining months of eligibility).

NOTE: If the new plan contains any exclusion or limitation for a pre-existing condition of the continuation enrollee, then coverage may not be terminated.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay 102% of the cost of benefits for the continuation coverage. Also, at the end of the continuation period you are allowed to convert to a self-paid direct payment policy.

Conversion Options

If you do not choose continuation, your City group coverage will end. You will still be offered the opportunity to convert your City health insurance benefits to a non-City direct payment health insurance policy and, where applicable, convert certain welfare fund benefits. Benefits offered under the non-City group direct payment health insurance policy are offered on a quarterly basis for an indefinite period of time, provided premiums are paid on time. These benefits may vary from the City's "basic" health benefits package in terms of scope of benefits and cost. Benefits available from welfare funds that may be converted to direct payment are insured medical/ surgical/ hospital and life insurance coverage. Such benefits may be converted within 45 days of termination of coverage.

In order to receive continuation coverage for welfare fund benefits or to convert to direct payment, you must contact your welfare fund directly.

For further information about this law, employees should contact their agency benefits representative and retirees should contact the Health Benefits Program, 40 Rector Street - 3rd Fl., New York, New York 10006.

**CITY OF NEW YORK EMPLOYEE BENEFITS PROGRAM
CONTINUATION OF COVERAGE APPLICATION**

COBRA

REASON FOR SUBMISSION		Date of Qualifying Event / /		<input type="checkbox"/> Transfer of Plans
<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Death of Employee/Retiree	<input type="checkbox"/> Reduction of Work Schedule <input type="checkbox"/> Loss of Eligibility as a Dependent Child	<input type="checkbox"/> Divorce <input type="checkbox"/> Legal Separation	<input type="checkbox"/> Termination of Domestic Partnership	
Present or Former Contract Holder's Name _____		Present or Former Health Plan _____		Social Security Number _____
Relationship to Present or Former Contract Holder		Present or Former City Employee's Welfare Fund _____		
<input type="checkbox"/> Self <input type="checkbox"/> Son	<input type="checkbox"/> Spouse (Former or Current) <input type="checkbox"/> Daughter	<input type="checkbox"/> Domestic Partner		

APPLICANT INFORMATION (Please Print)

Last Name _____		First Name _____	M.I. _____	Social Security # _____	Home Telephone # _____
Mailing Address _____			Apt. No. _____	Date of Birth _____ / _____ / _____	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City _____	State _____	Zip Code _____	Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Legally Separated	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership
Date of Event _____ / _____ / _____					
Is Applicant Covered by Another Group Policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Applicant Totally Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Applicant or Any Dependent Covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Complete Section Below		

MEDICARE INFORMATION

Applicant	Medicare Claim Number	Suffix	EFFECTIVE DATES		Spouse/ Partner or Dependent	Medicare Claim Number	Suffix	EFFECTIVE DATES	
			HOSP. INS. (PART A)	MED. INS. (PART B)				HOSP. INS. (PART A)	MED. INS. (PART B)

FAMILY INFORMATION (Attach a second form if necessary.)
List below all family members to be covered, including yourself. If your plan requires you to choose a specific Medical Group (HIP Plans) or Primary Care Physician (Other HMO's) you must indicate the name and number of the group or physician chosen.

Name	Birth Date MO DAY YR	Relationship	Check if Applicable			Name & Number of Medical Group, Primary Physician or Hospital/Physician Network	Covered by Other Group Insurance
			Full-Time Student	Permanently Disabled	Covered by Medicare Part A Part B		
APPLICANT	/ /	Self					
SPOUSE/PARTNER LAST FIRST M.I.	/ /	<input type="checkbox"/> Spouse <input type="checkbox"/> Partner					
DEPENDENT LAST(IF DIFF) FIRST M.I.	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
DEPENDENT LAST(IF DIFF) FIRST M.I.	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					
DEPENDENT LAST(IF DIFF) FIRST M.I.	/ /	<input type="checkbox"/> Son <input type="checkbox"/> Daughter					

HEALTH PLAN REQUESTED (Check the box before the plan you want and check "Yes" or "No" for the optional benefits rider.)

<input type="checkbox"/> Aetna US Healthcare HMO	<input type="checkbox"/> Aetna US Healthcare QPOS	<input type="checkbox"/> Cigna HealthCare	<input type="checkbox"/> DC 37 Med-Team
<input type="checkbox"/> Empire EPO-Nationwide	<input type="checkbox"/> Empire HMO-New York	<input type="checkbox"/> Empire HMO-New Jersey	<input type="checkbox"/> GHI-CBP/EBCBS
<input type="checkbox"/> GHI-HMO	<input type="checkbox"/> HealthNet	<input type="checkbox"/> HIP Prime HMO	<input type="checkbox"/> HIP Prime POS
<input type="checkbox"/> MetroPlus	<input type="checkbox"/> Vytra Health Plan	Other _____	

OPTIONAL BENEFITS? Yes No

WELFARE FUND - COBRA

Do you wish to purchase benefits from your welfare fund?
 Yes No

You must check "yes" to receive welfare fund benefits. A "no" response or not answering this question will prevent you from receiving COBRA continuation benefits from your welfare fund. A copy of this form will be sent from the health plan to your welfare fund as proof that you have applied under COBRA for the City benefits. Before making this decision you should contact your welfare fund for available options and costs. You will pay the union welfare fund directly for the cost of these benefits. You may choose both the optional rider and the welfare benefits, either of these options or neither of these options.

AUTHORIZATION

<p>I certify that the above information is correct. I fully understand that I am responsible for the full cost of any continuation of coverage and will be subject to the terms and conditions of the group contract.</p> <p align="right">_____ Applicant's Signature</p> <p align="right">_____ Date</p>	<p>I choose to waive my rights to extend my current health coverage under COBRA. I wish to convert to a direct payment policy. Please send me a conversion contract.</p> <p align="right">_____ Applicant's Signature</p> <p align="right">_____ Date</p>
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NON-MEDICARE COBRA Rates for Effective January 1, 2009

PLAN	Coverage	COBRA RATE
AETNA HMO	INDIVIDUAL BASIC	\$468.38
	FAMILY BASIC	\$1,302.88
	INDIVIDUAL with RIDER	\$574.66
	FAMILY with RIDER	\$1,552.07

AETNA QPOS	INDIVIDUAL BASIC	\$993.37
	FAMILY BASIC	\$2,435.80
	INDIVIDUAL with RIDER	\$1,147.50
	FAMILY with RIDER	\$2,812.99

CIGNA	INDIVIDUAL BASIC	\$549.34
	FAMILY BASIC	\$1,454.29
	INDIVIDUAL with RIDER	\$649.38
	FAMILY with RIDER	\$1,719.40

EMPIRE EPO	INDIVIDUAL BASIC	\$699.61
	FAMILY BASIC	\$1,747.04
	INDIVIDUAL with RIDER	\$786.41
	FAMILY with RIDER	\$1,959.80

EMPIRE HMO	INDIVIDUAL BASIC	\$469.79
	FAMILY BASIC	\$1,220.48
	INDIVIDUAL with RIDER	\$556.58
	FAMILY with RIDER	\$1,433.24

GHI HMO	INDIVIDUAL BASIC	\$480.66
	FAMILY BASIC	\$1,225.15
	INDIVIDUAL with RIDER	\$575.74
	FAMILY with RIDER	\$1,467.60

GHI-CBP/BCBS	INDIVIDUAL BASIC	\$354.54
	FAMILY BASIC	\$920.13
	INDIVIDUAL with RIDER	\$469.95
	FAMILY with RIDER	\$1,135.96

PLAN	Coverage	COBRA RATE
HEALTHNET	INDIVIDUAL BASIC	\$525.93
	FAMILY BASIC	\$1,358.76
	INDIVIDUAL with RIDER	\$703.78
	FAMILY with RIDER	\$1,818.51

HIP PRIME HMO	INDIVIDUAL BASIC	\$390.34
	FAMILY BASIC	\$956.83
	INDIVIDUAL with RIDER	\$486.32
	FAMILY with RIDER	\$1,191.99

HIP PRIME POS	INDIVIDUAL BASIC	\$509.17
	FAMILY BASIC	\$1,248.06
	INDIVIDUAL with RIDER	\$631.70
	FAMILY with RIDER	\$1,548.22

DC 37 MED TEAM PROGRAM	INDIVIDUAL BASIC	\$390.34
	FAMILY BASIC	\$956.83
	(NO RIDER AVAILABLE) INDIVIDUAL with RIDER	\$390.34
	FAMILY with RIDER	\$956.83

METROPLUS HEALTH PLAN	INDIVIDUAL BASIC	\$390.34
	FAMILY BASIC	\$956.83
	INDIVIDUAL with RIDER	\$478.01
	FAMILY with RIDER	\$1,147.51

VYTRA	INDIVIDUAL BASIC	\$463.21
	FAMILY BASIC	\$1,216.98
	INDIVIDUAL with RIDER	\$572.43
	FAMILY with RIDER	\$1,504.20

MEDICARE COBRA Rates for Effective January 1, 2009

PLAN	Coverage	COBRA RATE
GHI SENIOR CARE	PER PERSON BASIC	\$156.35
	PER PERSON with RIDER	\$258.41

GHI HMO	PER PERSON BASIC	\$257.50
	PER PERSON with RIDER	\$316.15

HEALTHNET	PER PERSON BASIC	\$235.64
MED PRIME	PER PERSON with RIDER	\$468.30

DC37 MED TEAM PROGRAM	PER PERSON BASIC	\$156.35
	RIDER NOT AVAILABLE	

EMPIRE MEDICARE RELATED PLAN	PER PERSON BASIC	\$218.77
	PER PERSON with RIDER	\$357.16

NOTE: If you were enrolled in a Medicare HMO you MUST contact your health plan DIRECTLY for benefit and cost information regarding continuation of coverage.

Return the completed COBRA form to your chosen plan. Addresses are listed on the front of this pamphlet. Wait for notification from the plan before mailing in your first payment. Checks and/or money orders must be made payable to the health plan and mailed DIRECTLY to the plan. Enrollees of all plans not listed must



**City of New York
Office of Labor Relations
Health Benefits Program**

COBRA Enrollment and Premiums

Under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), you have the opportunity to continue health benefits coverage through the City of New York group.

You are responsible for paying the full premium for your plan and coverage. The premium levels indicated on the back of this page reflect 102% of the current rate (because these rates are subject to change, you should check with the plan to determine the premium at the time of your COBRA enrollment). Payments may be made monthly on the first of the month. There is usually a 30 day grace period. The City will not "carve out" benefits provided through your Welfare Fund that are similar to those available in your plan's Optional Rider. If you decide to purchase the Optional Rider, you must pay for the entire Optional Rider offered by your chosen plan. If you decide to purchase any of your Welfare Fund benefits, you should contact the Welfare Fund to determine what benefits are available, and the associated cost.

Health Plan Addresses

Payment should be mailed directly to the plan chosen for COBRA continuation coverage. The plan addresses are:

Aetna HealthCare
575 Pigeon Hill Road
Windsor, CT 06096
Attn: Michele Wrann, WP22

Empire BlueCross BlueShield
3 Huntington Quadrangle 4 Fl.
Melville, NY 11747
Attn: Cynthia Robinson

HealthNet
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944
Attn: Enrollment Dept.

Metro Plus Health Plan
160 Water Street, 3rd Fl.
New York, NY 10038
Attn: Finance Department

CIGNA Healthcare
499 Washington Blvd.
Jersey City, NJ 07310
Attn: Alejandra Tavera

Group Health Inc.*
441 Ninth Ave.
New York, NY 10001
Attn: Membership Dept.

HIP Prime HMO
HIP Prime POS
55 Water Street
New York, NY 10041
Attn: Len Proctor

VYTRA HealthCare
55 Water Street
New York, NY 10041
Attn: Len Proctor

DC 37 Med-Team
125 Barclay Street, 3 Fl.
New York, NY 10007
Attn: Robert Hasiek

GHI HMO
P.O. Box 4181
Kingston, NY 12402
Attention: Linda Piro

*The GHI-CBP/EBCBS is offered as a package under COBRA. The premium should be sent to the Group Health Inc. address indicated above.

CONVERSION CONTRACTS - City Health Plan Benefits

If you do not wish to continue coverage under COBRA you may use the same application to request direct payment conversion contracts from all plans. Conversion contract payments will be due quarterly. Upon receipt of an application for conversion, the health plan will send you a direct payment contract and a bill. Generally, conversion contracts will be more expensive than COBRA for the same benefits or will offer benefits less comprehensive than COBRA, with the exception of certain Medicare supplemental contracts. Optional benefits are not available under conversion. You may purchase either Group Health Inc. or Empire BlueCross BlueShield direct payment plan separately. Decide whether direct payment conversion or COBRA continuation coverage is best to meet your needs. If you decide to continue coverage under COBRA, you will again be eligible to obtain direct payment contracts when COBRA terminates. Contact the health plan for more information concerning direct payment contracts.

Welfare Fund Benefits

Contact your welfare fund directly for COBRA rates. If you do not wish to continue coverage of benefits provided by your welfare fund under COBRA, conversion to private coverage may be available for medical and life insurance benefits within 45 days of termination of coverage. If you intend to obtain welfare fund benefits under COBRA, please so indicate on the COBRA Continuation of Coverage application.



**City of New York
Office of Labor Relations
Health Benefits Program**

Welfare Fund Administrators

This listing includes all City of New York welfare funds. If you wish to continue your benefits under COBRA, the information concerning welfare fund options and premiums can be obtained from your fund.

Allied Building Inspectors, Local 211
225 Broadway, 43rd Floor
New York, NY 10007

Assistant Deputy Wardens Association
303 Merrick Blvd.
Lynbrook, NY 11563

Bridge and Structural Iron Workers
451 Park Ave. South, 9th Floor
New York, NY 10016

Civil Service Bar Association
216 West 14th Street
New York, NY 10011

Civil Service Forum, Local 300
180 Broadway, Suite 800
New York, NY 10038

Committee of Interns and Residents House Staff Benefits
520 8th Avenue, Suite 1200
New York, NY 10018

Communication Workers of America, Local 1180
6 Harrison Street, 3rd Floor
New York, NY 10013

Communication Workers of America, Local 1181
25-04 41st Ave.
Long Island City, NY 11101

Communication Workers of America, Local 1182
108-18 Queens Blvd.
Forrest Hills, NY 11375

Communication Workers of America, Local 1183
6 Harrison Street, 4th Floor
New York, NY 10013

Corrections Captains Association
233 Broadway, Suite 1701
New York, NY 10279

Correction Officers Benevolent Association
335 Broadway, Room 915
New York, NY 10013

Council of Supervisors and Administrators
16 Court Street, 34th Floor
Brooklyn, NY 11241

International Union of Operating Engineers, Local 891
4600 Broadway
New York, NY 10040

Deputy Sheriffs Association
36-22A Francis Lewis Boulevard, Suite 208
Queens, NY 11358

Detectives Endowment Association
26 Thomas Street
New York, NY 10013

District Council 37 Benefits Fund Trust
125 Barclay Street
New York, NY 10007

Doctors Council Welfare Fund
21 East 40th Street, 8th Floor
New York, NY 10016

Fire Alarm Dispatchers Benevolent Association
204 East 23rd Street, 3rd Floor
New York, NY 10010

International Brotherhood of Boilermakers, Iron Ship
Builders, Blacksmiths, Forgers, and Helpers, AFL-CIO
24 Van Siclen Ave
Floral Park, NY 11001

International Brotherhood of Electrical Workers, Local 3
158-11 Harry Van Arsdale Ave.
Flushing, NY 11365

International Brotherhood of Teamsters, Local 237
216 West 14th Street
New York, NY 10011

International Brotherhood of Teamsters, Terminal
Employees, Local 832
267 Broadway
New York, NY 10007

International Longshoremen's Association,
Local 333 - United Marine Division
552 Bay Street
Staten Island, NY 10304

International Union of Operating Engineers, Local 14, 14B
141-57 Northern Blvd.
Flushing, NY 11354

International Union of Operating Engineers, Local 15
265 West 14th Street
New York, NY 10011

International Union of Operating Engineers, Local 30
115-06 Myrtle Avenue
Richmond Hill, NY 11418

Local 1989, DC9, IBPAT
45 West 14th Street, 3rd Floor
New York, NY 10011

Licensed Practical Nurses, Local 721
322 West 48th Street – 6th Floor
New York, NY 10036

Management Benefits Fund
40 Rector Street, 3rd Floor
New York, NY 10006

MEBA City Employees Benefit Services
1007 Eastern Avenue
Baltimore, MD 21202

IATSE, Local 306
545 West 45th Street, 2nd Floor
New York, NY 10036

1199 National Benefit Fund for Hospital
Health Care Employees
310 West 43rd Street
New York, NY 10036

Local 246, SEIU
217 Broadway, Suite 501
New York, NY 10007

NYS Nurses Association
120 Wall Street, 23rd Floor
New York, NY 10005

Organization of Staff Analysts
220 East 23rd Street, Suite 707
New York, NY 10010

Patrolmen's Benevolent Association
40 Fulton Street
New York, NY 10038

Pavers and Roadbuilders, District Council
136-25 37th Avenue
Flushing, NY 11354

U.A. Plumbers & Gasfitters, Union Local 1
158-29 Cross Bay Blvd.
Howard Beach, NY 11414

Police Benevolent Association of the
District Attorney's Office
P.O. Box 130405
New York, NY 10013

Professional Staff Congress,
CUNY Welfare Fund
25 West 43rd Street
New York, NY 10036

Sergeant's Benevolent Association
35 Worth Street – 1st Floor
New York, NY 10007

S.E.I.U. Welfare Fund, Local 621
75 Darcy Circle
Islip, NY 11751

Social Service Employees Union, Local 371
817 Broadway
New York, NY 10003

Steamfitters-Local Union 638 of the United Association
AFL-CIO
32-32 48th Ave
Long Island City, NY 11101

Structural Street and Bridge Painters, Local 808
40 West 27th Street, 10th Floor
New York, NY 10001

Superior Officers Council
233 Broadway, 8th Floor
New York, NY 10274

Uniformed Fire Fighters Association of Greater New York
204 East 23rd Street, 5th Floor
New York, NY 10010

Uniformed Fire Officers Association, Local 854
225 Broadway, Room 401
New York, NY 10007

Uniformed Sanitation Officers Association
8510 Bay 16th Street – 2nd Floor
Brooklyn, NY 11214

Uniformed Sanitationmen's Association, Local 831
23-25 Cliff Street
New York, NY 10038

United Brotherhood of Carpenters and Joiners
District Council of New York and Vicinity
395 Hudson Street, 8th Floor
New York, NY 10014

United Federation of Teachers Welfare Fund
52 Broadway – 7th Floor
New York, N.Y.10004

United Probation Officers Association
375 West Broadway, Room 300
New York, NY 10013



THE CITY OF NEW YORK
OFFICE OF LABOR RELATIONS

EMPLOYEE BENEFITS PROGRAM

40 RECTOR STREET, NEW YORK, NY 10006-1705

<http://nyc.gov/olr>

JAMES F. HANLEY
Commissioner
MARGARET M. CONNOR
First Deputy Commissioner

DOROTHY A. WOLFE
Director, Employee Benefits Program
GEORGETTE GESTELY
Director, Pre-Tax Programs
LISA POLK
Director, Health Benefits Program
DENNIS STEINER
*Director, Financial and
Systems Management*

COBRA CONTINUATION COVERAGE ELECTION NOTICE

This notice contains information about additional rights you may have related to your COBRA continuation coverage for your City of New York Health Plan.

The American Recovery and Reinvestment Act of 2009 (ARRA) signed by President Obama on February 17, 2009 reduces the COBRA premium in some cases. You are receiving this election notice because you have experienced a loss of coverage that occurred during the period that begins September 1, 2008 and ends December 31, 2009 and you may be eligible for the temporary premium reduction for up to nine months beginning on or after February 17, 2009. The premium reduction is available to certain individuals who experience a qualifying event that is an "involuntary termination of employment" during the period stated above. For reasons other than the involuntary termination, such as death, divorce or overage dependents do not qualify for the COBRA subsidy.

To help determine whether you are eligible for the ARRA premium reduction, you must read the "Summary of the COBRA Premium Reduction Provision under ARRA" on the back of this notice. For additional information visit our website at www.nyc.gov/olr and click on "ARRA". This information includes details regarding eligibility, restrictions and obligations and COBRA subsidy rates. If you do not have access to the internet you can request a package containing this information by writing to this office, Attention: ARRA. Please make sure you include your name, your Employee ID#, your complete address, and the name of your former Agency.

If you qualify for the subsidy you will pay 35% of the COBRA premium to your health plan for up to nine months. **You must follow the instructions on the back of the enclosed request form in order to apply for the subsidy.** If you are already enrolled for COBRA and meet the qualifications for the subsidy you will receive a refund (or a credit) from the health plan for any excess premium paid for periods after February 17, 2009.

If you experienced a qualifying event as the result of an involuntary termination of employment any time from September 1, 2008 through February 16, 2009, and were offered, but did not elect COBRA continuation coverage OR elected COBRA continuation coverage and subsequently discontinued it, you may have the right to an additional 60-day election period. **You must follow the instructions on the back of the enclosed request form in order to apply for the subsidy.**

Contact your union welfare fund for information about its COBRA benefits.

April 17, 2009

INSTRUCTION SHEET

“REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL” Form

FOLLOW INSTRUCTIONS CAREFULLY:

1. Read the “SUMMARY OF THE COBRA PREMIUM REDUCTION PROVISIONS UNDER ARRA”.
2. Complete the request form on the other side of this notice in full. Sign and date the request form.
3. Submit the request form to the Human Resource/Personnel Department of your former agency for verification of “involuntary termination of employment”. (In order to expedite verification bring the application in person to the agency personnel office). The agency will validate the request within 1 business day and return it to the applicant.
4. Once the request form is signed by the authorized agency personnel the applicant must submit the request form to the health plan (see addresses below). Keep a copy for your records.
 - If you are not enrolled in COBRA with the health plan you must submit the request form along with a completed COBRA application which you can obtain from your former agency or from our website at www.nyc.gov/olr . If you do not have access to the internet you can also request a package containing a COBRA application and information by writing to the New York City Health Benefits Program, 40 Rector Street, 3rd Floor, NY, NY 10006, Attention: ARRA. You must include your name, your Employee ID#, your complete address, and the name of your former Agency. COBRA applications must be submitted within 60 days of this notice. The effective date of the COBRA will be February 17, 2009 or your date of involuntary termination whichever is later.
 - If you are already enrolled in COBRA with the health plan there is nothing more for you to do.
 - If you qualify for the subsidy you will receive the reduced premium automatically.

Health Plan Addresses

REQUEST FORM must be mailed directly to the health plan chosen for COBRA continuation coverage at the appropriate address below.

Aetna HealthCare
575 Pigeon Hill Road
Windsor, CT 06095
Attn: Connie Provencher

Empire BlueCross BlueShield
3 Huntington Quadrangle, 4 Fl.
Melville, NY 111747
Attn: Cynthia Robinson

Health Net
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944
Attn: Enrollment Department

Metro Plus Health Plan
160 Water Street, 3 FL.
New York, NY 10038
Attn: Yasmine Pantou

CIGNA Healthcare
499 Washington Blvd., 4th Fl.
Jersey City, NJ 07310
Attn: Dan Moskowitz

Group Health Inc.
441 Ninth Avenue
New York, NY 10001
Attn: Membership Department

HIP Prime HMO
HIP Prime POS
441 Ninth Avenue
New York, NY 10001
Attn Membership Department

VYTRA HealthCare
441 Ninth Avenue
New York, NY 10001
Attn: Membership
Department

DC37 Med-Team
125 Barclay Street, 3rd Fl.
New York, NY 10007
Attn: Robert Hasiak

GHI HMO
P.O. Box 4181
Kingston, NY 12402
Attn: Linda Pino



Summary of the COBRA Premium Reduction Provisions under ARRA



President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. The law gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months.

To be considered an "Assistance Eligible Individual" and get reduced premiums you:

- MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
- MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
- MUST NOT be eligible for Medicare; AND
- MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

◆ IMPORTANT ◆

- ◇ **If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.**
- ◇ **Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.**
- ◇ **The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.**

For general information regarding your plan's COBRA coverage, for specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums you must contact your health plan directly.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.dol.gov/COBRA or call 1-866-444-EBSA (3272)

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form, have it validated by your former agency and return it to your health plan. Follow the instructions on the back of this form. If you are not currently enrolled in COBRA see "Additional Election Period" below.

You may also want to read the important information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA."

CITY OF NEW YORK
HEALTH BENEFITS
PROGRAM

**REQUEST FOR TREATMENT AS AN ASSISTANCE
ELIGIBLE INDIVIDUAL**

HEALTH PLAN
ADDRESS ON
BACK OF FORM

PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)

Telephone number

E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.*

- | | |
|---|--|
| 1. The loss of employment was involuntary. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. The loss of employment occurred at some point on or after September 1, 2008 and on or before December 31, 2009. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. I elected (or am electing) COBRA continuation coverage.* | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium). | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium). | <input type="checkbox"/> Yes <input type="checkbox"/> No |

*If you checked NO for statement 3, you may still be eligible. See below for more information.

ADDITIONAL ELECTION PERIOD

If your COBRA continuation coverage relates to an involuntary loss of employment from September 1, 2008 through February 16, 2009 and you were eligible for, but did not elect, COBRA continuation coverage **OR** you elected but subsequently discontinued COBRA, you may have the right to an additional 60-day election period. If you now wish to enroll you must complete a new COBRA application which you can obtain from your former Agency or on our website at www.nyc.gov/olr and click on "ARRA". If you do not have access to the internet you can also request a package containing an application and information by writing to the New York City Health Benefits Program, 40 Rector Street, 3rd Floor, NY, NY 10006, Attention: ARRA. You must include your name, your Employee ID# or Social Security #, your complete address, and the name of your former Agency.

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____ Social Security # _____

Type or print name _____ Relationship to employee _____

FOR EMPLOYER USE ONLY

Agency to Complete

This application is: Approved Denied

Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

- | | |
|--|--------------------------|
| 1. Loss of employment was voluntary. | <input type="checkbox"/> |
| 2. The involuntary loss did not occur between September 1, 2008 and December 31, 2009. | <input type="checkbox"/> |
| 3. Other (please explain) | <input type="checkbox"/> |

I certify that this information is true and correct.

Signature of Agency Authorized Representative _____

Print name _____

Telephone # _____ Agency Address _____